MEDICAL RECORD	REPORT OF MEDICAL EXAMINATION	DATE OF EXAM

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. IDENTIFICATION NO.	3. GRADE AND COMPONENT OR POSITION
4. HOME ADDRESS *(Number, street or RFD, city or town, state and ZIP code)*	5. EMERGENCY CONTACT *(Name and address of contact)*	
6. DATE OF BIRTH	7. AGE	8. SEX ☐ FEMALE ☐ MALE
9. RELATIONSHIP OF CONTACT		
10. PLACE OF BIRTH	11. RACE ☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN/ ALASKA NATIVE ☐ HISPANIC WHITE ☐ HISPANIC BLACK ☐ ASIAN/PACIFIC ISLANDER	
12a. AGENCY	12b. ORGANIZATION UNIT	13. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY b. CIVILIAN
14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS	15. RATING OR SPECIALTY OF EXAMINER	16. PURPOSE OF EXAMINATION

CLINICAL EVALUATION

NOR-MAL	*(Check each item in appropriate column; enter "NE" if not evaluated.)*	ABNOR-MAL	NOR-MAL	*(Check each item in appropriate column; enter "NE" if not evaluated.)*	ABNOR-MAL
	A. HEAD, FACE, NECK AND SCALP			O. PROSTATE *(Over 40 or clinically indicated)*	
	B. EARS-GENERAL *(INTERNAL CANALS)* *(Auditory acuity under items 39 and 40)*			P. TESTICULAR	
				Q. ANUS AND RECTUM *(Hemorrhoids, Fistulae) (Hemocult Results)*	
	C. DRUMS			R. ENDOCRINE SYSTEM	
	D. NOSE			S. G-U SYSTEM	
	E. SINUES			T. UPPER EXTREMITIES *(Strength, range of motion)*	
	F. MOUTH AND THROAT			U. FEET	
	G. EYES-GENERAL *(Visual acuity and refraction under items 28, 29, and 36)*			V. LOWER EXTREMITIES *(Except feet) (Strength, range of motion)*	
	H. OPTHALMOSCOPIC			W. SPINE, OTHER MUSCULALSKELETAL	
	I. PUPILS *(Equality and reaction)*			X. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	J. OCULAR MOTILITY *(Associated parallel movements nystagmus)*			Y. SKIN, LYMPHATICS	
	K. LUNGS AND CHEST			Z. NEUROLOGIC (Equilibrium tests under item 41)	
	L. HEART *(Thrust, size, rythm, sounds)*			AA. PSYCHIATRIC (Specify and personality deviation)	
	M. VASCULAR SYSTEM *(Varicosities, etc.)*			BB. BREASTS	
	N. ABDOMEN AND VISCERA *(Include hernia)*			CC. PELVIC *(Females only)*	

NOTES. *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary.)*

18. DENTAL *(Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)*

Restorable Teeth	Non-Restorable Teeth	Missing Teeth	Replaced by dentures	Fixed Partial dentures
0 1 2 3 32 31 30 0	/ 1 2 3 32 31 30 /	x 1 2 3 32 31 30 x	x x x 1 2 3 32 31 30 x x x	(x) 1 2 3 32 31 30 (x)

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS (1) SPECIFIC GRAVITY		B. CHEST X-RAY OR PPD *(Place, date, film number and result)*
(2) URINE ALBUMIN	4. MICROSCOPIC	
(3) URINE SUGAR		
C. SYPHILIS SEROLOGY *(Specify test used and results)*	D. EKG / E. BLOOD TYPE AND RH FACTOR	F. OTHER TESTS

NAME	IDENTIFICATION NO.	NO. OF SHEETS ATTACHED

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD ☐ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE	26. TEMPERATURE

26. BLOOD PRESSURE *(Arm at heart level)*

A. SITTING	SYS.	DIAS.	B. RECUMBENT	SYS.	DIAS.	C. STANDING *(5 min.)*	SYS.	DIAS.

27. PULSE *(Arm at heart level)*

A. SITTING	B. RECUMBENT	C. STANDING *(3 mins.)*	D. AFTER EXERCISE	E. 2 MINS AFTER

28. DISTANT VISION		29. REFRACTION			30. NEAR VISION	
RIGHT 20/	CORR. TO 20/	BY	S	CX	CORR. TO	BY
LEFT 20/	CORR. TO 20/	BY	S	CX	CORR. TO	BY

31. HETEROPHORIA *(Specify distance)*

FSO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

32. ACCOMMODATION	33. COLOR VISION *(Test used and result)*	34. DEPTH PERCEPTION *(Test used and score)*	UNCORRECTED / CORRECTED
RIGHT LEFT			

35. FIELD OF VISION	36. NIGHT VISION *(Test used and score)*	37. RED LENS TEST	38. INTRAOCULAR TENSION
RIGHT LEFT			RIGHT LEFT

39. HEARING

RIGHT WV /15 SV /15

LEFT WV /15 SV /15

40. AUDIOMETER

	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
RIGHT								
LEFT								

41. PSYCHOLOGICAL AND PSYCHOMOTOR *(Tests used and score)*

42. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

44. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*

45A. PHYSICAL PROFILE

P	U	L	H	E	S

46. EXAMINEE *(Check)*

A. ☐ IS QUALIFIED FOR

B. ☐ IS NOT QUALIFIED FOR

45B. PHYSICAL CATEGORY

A	B	C	E

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFFECTS BY ITEM NUMBER

48. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
49. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	SIGNATURE
51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE